Robert Bos, MD
515 Madison Avenue, 6th Floor
New York, NY 10022

PATIENT FINANCIAL RESPONSIBILITY

Patient Name:_____

Insurance:_____

Effective Date:_____

Total Insurance Deductible:_____

Total Deductible Paid to Date: _____as of ____/____/_____(date)

Total Remaining Deductible:_____

Coinsurance: (e.g. 70/30)_____

Coinsurance payments: _____
(Coinsurance is the fee you pay after your deductible is met. We will try to estimate your financial responsibility at the time of your visit, but this amount may change depending on your specific insurance reimbursement. As such, you may receive a bill at a later date for the remaining balance.)

Fees for Dr. Bos' services are as follows:

New Patient Visit/Initial Evaluation ranges from $300 - $500

Diagnostic/Treatment

Follow-Up	$250.00	Echocardiogram	$500.00
Well Physical	$450.00	Carotid/Aortic Ultrasound	$200.00
Sick Visit – Established Pt	$250.00	Chest X-Ray	$150.00
Visa Examination	$400.00	Sinus X-Ray	$200.00
Home visits	$600.00	Spirometry	$100.00
Email/phone consultation	$100.00	Hearing Screening	$75.00
PVR	$200.00	Blood draw	$50.00
EKG	$100.00	All Immunizations	$100.00-$200.0

Nutrition Program
Initial, $175 / Follow up, $87.50

I, _____, understand that I am responsible for payment of the fees applicable for the services rendered by Dr. Bos at each appointment. I understand that the fees for these services are subject to change and I will be notified of that prior to receiving treatment. I understand that the above listed fees are not exhaustive and that additional fees may be incurred, which I will be aware of prior to receiving treatment.

I understand that Dr. Bos does not accept all insurance plans and is out-of-network with all insurances accepted. I understand that I am responsible for payment of the applicable deductible/coinsurance for services rendered by Dr. Bos and his associate(s). Out-of-network deductibles are due in full at the time of service. A payment towards the coinsurance will be due at the time of service and I will be balance billed by Dr. Bos' office for any additional coinsurance amount owed to Dr. Bos.

I understand that some insurance carriers do not allow out-of-network providers to be paid directly. I understand that should I receive payment from my insurance carrier for services rendered by Dr. Bos that I am responsible to provide either the endorsed insurance check payable to Dr. Bos or a personal payment to Dr. Bos in the same amount via cash, personal check or credit card. I will also provide all Explanation of Benefits (EOBs) from my insurance carrier with these payments.

I understand that should my insurance company deny any services provided, I will be responsible for the balance. In some cases, patients may choose to receive services that are not covered by insurance, and are financially responsible to pay for such services as will be discussed prior to receiving those services.

I understand that I may have limited benefits and/or visits allowed with certain providers under my insurance plan. I understand that while the office staff will do its best to verify my out-of-network benefits, deductibles, coinsurance and track the number of allowable visits under my plan as applicable, it is ultimately my responsibility to verify my benefits and track the use of these benefits under my plan. Further, I understand that if I exceed the number of allowable visits, I may be financially responsible for any visits and services rendered that are not covered by my insurance plan.

I will promptly provide the office with any changes in my existing insurance coverage. I understand that I am responsible for providing Dr. Bos' office with up-to-date insurance information and appropriate referrals, if required by my insurance plan.

If you have billing questions, please contact Stacey Szarka, Billing Manager at (212) 752-6770 or sszarka@truwholecare.com.

_____

Patient Print Name

_____

Signature Date

As a practice policy for Dr. Robert Bos, we will be taking an imprint of your credit card and will process the payments for services received ONLY if balances due are not received within eight (8) weeks from your office visit. Your card will not be run without prior notification.

FOR OFFICE USE ONLY

I _____(staff member) have discussed the financial responsibilities with the above listed patient and he/she understands Dr. Bos' policies as outlined in this form.

_____

Staff Member Print Name

_____

Signature Date